

Social Insurance: A Critical Base for Financing Long-Term Services and Supports

Introduction

As the demand for long-term services and supports (LTSS) increases sharply, only a small percentage of the population that will need nursing or home care has coverage ahead of time through either a private plan or a public program. While a small percentage of people can self-insure, the challenge is to address the needs of the large group in the middle of the income distribution that faces a significant gap between the resources required to maintain their quality of life and what they can actually afford at the time they need care. The growing financial burden on state Medicaid programs means this will be both a political and a policy imperative.

An Insurance-Based Approach

Aging is a certainty, but there are large variations in LTSS expenditures among individuals. Spreading the financial risk of needing LTSS across a large population is efficient, since it reduces the amount an individual must set aside to try to cover his or her potential expenses. Saving enough to cover the average cost of care is much less than saving for the maximum potential cost of care. Pooling risks also increases the resources available to the community since individuals tend to underestimate the amount of LTSS they will need and overestimate their access to informal care.

Insuring an individual against the risk of needing LTSS continues to be a challenge for the private sector. The probability and the cost of a claim, combined with the voluntary nature of private coverage require private insurers to either limit their exposure (by limiting services or excluding the highest risk individuals through medical underwriting) or to pass potential losses on to the consumer in the form of higher premiums. Social insurance is universal and contributory and offers a benefit based on a triggering event.

Social and private insurance are not, however, mutually exclusive options for managing risk. The floor of income promised through Social Security has encouraged the accumulation of trillions of dollars in supplementary private savings and pensions. Other countries manage long-term care systems that incorporate elements of both social and private insurance along with a robust safety net.

Applying the Social Insurance Construct to LTSS Policy Solutions

Financing the LTSS needs of a heterogeneous population requires a mix of benefit designs and funding mechanisms. One approach is to expand the medical benefit provided through Medicare to include both institutional and community residential and social service benefits necessary to support beneficiaries with functional limitations. There are many different approaches to expanding Medicare to cover long-term non-medical services. Doing so, however, poses challenges in applying additional eligibility criteria within the context of Medicare that would target these services effectively to severely functionally-limited beneficiaries. Chart 1 outlines the options for expanding Medicare to cover LTSS.

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Chart 1. Options for Expanding Medicare to Cover LTSS

Type of Benefit	Description	Comment
Incremental Benefit	Modify Part A by eliminating the “home bound” requirement for home health benefit and the three-day hospital rule for skilled nursing facility coverage.	Helps with post-acute care, increases access to skilled care. Does not help with people seeking access to home and community based services (HCBS) or custodial care.
Temporary, First-Dollar Coverage	Expand Part A to provide time-limited access to custodial nursing care, HCBS, transitional care services. May include consumer-directed, agency-provided HCBS.	Assists all activity of daily living (ADL)-eligible individuals with LTSS needs; allows some individuals to avoid or postpone institutionalization. Reduces Medicaid expenditures. Allows for respite care. Younger people with disabilities likely to outlast the benefit. Avoids federal open-ended liabilities.
Catastrophic Coverage	Expand Part A to include a lifetime benefit covering most out-of-pocket costs after significant waiting period (2-3 years or \$50,000 in services).	Helps small number of people with high-cost needs. Reduces state Medicaid expenditures by transferring custodial care in nursing homes and other high cost cases to Medicare. Most people who become Medicaid eligible will continue to rely on Medicaid for services below the threshold. Increases reimbursement for providers. Creates insurable zone, but marginal increase in private insurance coverage likely to be small.
Comprehensive Public Insurance	<p>(1) Create a Medicare Part E with similar benefits as above. Voluntary enrollment during limited window of time. Subsidies, added cost-sharing on existing Medicare benefits that overlap with LTSS to control for adverse selection.</p> <p>(2) Expand Part A to cover LTSS services similar to what is currently offered by private plans. Mandatory enrollment; no medical underwriting, no subsidies.</p>	Designed to cover needs of the average older adult. Waiting period unlikely to impose major financial burden. Expansion of Part A to become the basis for expanded Medicare Advantage (MA) coverage. Private LTSS insurance would be eliminated.
Managed LTSS	<p>(1) MA plans permitted to add LTSS as optional supplemental benefit and charge enrollees an additional premium. Benefits, premiums would vary among plans.</p> <p>(2) Mandatory expansion of current MA program to cover specified benefits; plans would have flexibility to offer additional benefits.</p>	Provides LTSS as part of a package of integrated care. Concern whether MA plans will have experience integrating acute care and LTSS, but current Financial Alignment Demonstrations should provide the Center for Medicare & Medicaid Services with expertise and may bring Medicaid managed care plans into Medicare.

Another option is to create a monetary benefit that might supplement Social Security. Such an approach provides consumers with the flexibility to select the goods and services that best meet their unique needs. A cash benefit is particularly appropriate for non-medical services that do not require a clinical evaluation and can be selected and managed most effectively by individual patients and their caregivers. A monetary benefit has the disadvantage of being potentially more expensive than reimbursing for items or services since the benefit requires a separate eligibility determination in order to target it to the most severely functionally limited. It also can be difficult to ensure the quality of care provided and guard against inappropriate payments to third parties. A monetary payment also requires an administrative structure that includes periodic reassessments and other forms of oversight. One could also cap coverage by limiting the benefit to the cost of a specific basket of services.

Financing Mechanisms for Social Insurance

Additional social insurance benefits to provide LTSS may be financed primarily by current workers and taxpayers or by beneficiaries or by a combination of the two. Traditional financing for Social Security and Medicare Part A has been through intergenerational transfers that build on the promise that today's contributing workers will receive their retirement benefits financed by future generations of workers. A current benefit that contributing workers realize is the security and peace of mind for parents and other family members who are retired or disabled beneficiaries.

The disadvantage of payroll tax financing is its proportionality, which makes it moderately regressive, particularly when taxable wages are capped. LTSS could be financed more progressively by current workers and taxpayers through the income tax. Alternatively, Medicare Part B and Part D are financed through premiums paid by current beneficiaries combined with subsidies from general tax revenues. Participation in the tax-financed programs is mandatory, whereas participation in premium-financed programs is voluntary (with an opt-out in Part B and an opt-in in Part D). General revenue subsidies in Part B and Part D substantially reduce the premium cost to beneficiaries, providing a strong incentive to enroll. Reliance on a premium to finance an LTSS benefit could shift some portion of the costs from wage earners to taxpayers more broadly and reinforce the notion that the program is a form of insurance. While a uniform premium is the most regressive form of financing, it can be moderated by subsidies for low-income beneficiaries (as with Medicare Part D) or means-tested for higher-income beneficiaries (as with Medicare Part B).

Conclusion

The current system provides assistance with LTSS on a means-tested basis, once people are already impoverished. A social insurance approach, in contrast, would allow people to spread risk and plan ahead for their LTSS needs. A universal compulsory program that spreads risk broadly could improve access to affordable services, relieve the burden on state Medicaid programs, and provide a mechanism for Americans to take greater personal responsibility for their LTSS needs.

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